For office use only:

MRN:_______________________

Portal Access Form for Patient/Proxy

I.Patient Information:*
Patient Name: ____
Last First Middle

Nickname:____

Date of Birth:_________________Social Security Number:_______-____-__________ Phone Number:______-______-_______

Address:____ ___________________________________
Street address City/State Zip code Email Address

X____ _____________________________ ________________________
Parent/Legal Guardian signature * Relationship to Patient* Date
OR Patient signature if 18 or over

II. Proxy Information: (Proxy is the person who will have access to view records on the Patient Portal)

Proxy Name:____
Last First M.I.

Address:____
Street Address City/State Zip code

Email address:____

Phone Number:________-________-___________ Relationship to Patient:______________________________________

Does the proxy have an active Patient Portal account for another patient? Yes______ No_______

*note: Legal Guardians must attach a copy of the court order appointing guardian and/or letters of guardianship verifying the Proxy's status as legal guardian of the patient.
* If you are faxing this form, please attach a copy of your valid photo ID

III. Signature: By signing below, I acknowledge and agree that I will comply with the Patient Portal Terms and Conditions. If I am a Proxy for a patient over 18 I understand that the patient can cancel my access to his/her ETCH Patient Portal at any time.

X ______________________________________ ___________________
Proxy Signature * Date

X ______________________________________ _________________________________ ____________________
Patient Signature Witness Date
(by signing you acknowledge and agree to allow access to the Proxy listed above)

***required information**